Small Hands, Big Results

Advisory Committee
First 5 San Bernardino
Priority Recommendations Report
October 2011

Prepared by
Harder+Company
Community Research

FIRST 5 SAN BERNARDINO
Children and Families Commission for San Bernardino County

Advisory Committee
First 5 San Bernardino
Priority Recommendations Report
October 2011

TABLE OF CONTENTS

Small Hands, Big Results

Advisory Committee
First 5 San Bernardino
Priority Recommendations Report
October 2011

Prepared by
Harder+Company
Community Research

Background and Purpose

In March 2011, Governor Jerry Brown announced his intention to take $1 billion in reserves from Children and Families Commissions Statewide. Subsequently, AB 99 legislation was passed. This resulted in a loss to First 5 San Bernardino (F5SB) of approximately $50 million from the current fund balance. The Commission and F5SB staff immediately began preparing for the potential impacts of this cut.

In April 2011, the Commissioners agreed to take two courses of action to deal with the projected loss of fund reserves: First the Commissioners voted to maintain 2011-12 funding levels as they had been awarded but to sunset all contracts as of the end of the 2011-12 fiscal year. While the Commission could have opted to sunset funding at the end of the 2010-11 fiscal year, this would likely have created a hardship for many contractors. Second, the Commissioners requested the Advisory Committee, (an established body of experts who regularly provide advice and information to the Commission) to create a set of recommendations for funding areas beginning with the 2012-13 fiscal year. The recommendations in this report are the result of more than seven months of work by this group. They represent a rigorous process that was guided by the strategic plan and utilized the most credible and current data accessible.

Criteria

At the outset of the process the Advisory Committee developed a set of criteria to guide the prioritization process. These criteria were presented to the Commission at the June 2011meeting.

- The process would be guided by the Strategic Plan. F5SB's strategic plan is current (adopted by the Commission in 2010), was developed thoughtfully using many resources, and is relevant to children age 0 to 5 and their families.

FIRST 5 SAN BERNARDINO
Children and Families Commission for San Bernardino County

- Recommendations would be based on evidence of need using credible, county-level data. Preliminary indicators of need were taken from the F5SB Evaluation Framework (which includes the indicators that F5SB reports to the State Children and Families Commission).

The Process

The Advisory Committee met monthly from March through September 2011 for meetings ranging from 2 to 4 hours. The Committee was broken into three workgroups (subcommittees), each taking on a focus area from F5SB's Strategic Plan (Education, Health, and Family). **Table 1** below outlines the work plan for the process month-by-month.

Table 1. F5SB Advisory Committee 2011-12 RFP Priority Setting Process

Session Topics	Tentative Date	Goals & Objectives
Building the Foundation	March/April 2011	▪ Identify considerations/criteria ▪ Develop process ▪ Present strategy to Commission
Where We Are and Where Do We Go From Here	May	▪ Assignment to subcommittees ▪ Revisit considerations ▪ Overview of timelines, support materials and process ▪ Review F5SB Objectives ▪ Review existing data ▪ Identify additional data needs ▪ Preview next session
Identify Priorities Within Focus Area	June	▪ Review and evaluate additional data ▪ Draft preliminary recommendations w/in subcommittees ▪ Identify additional data needs ▪ Preview next session
Present Preliminary Recommendations to Advisory	July	▪ Subcommittees present preliminary recommendations to Advisory Committee (entire group) ▪ Discussion/feedback for each group ▪ Identify additional data needs ▪ Finalize recommendations (in subcommittee) ▪ Preview next session
Suggested Strategies for Priority Areas	August	▪ Review priorities from each group ▪ Generate strategies aligned with each priority area ▪ Discuss content and structure of final report ▪ Preview next session
Finalize Recommendations	September	▪ Provide feedback on final recommendations report (sent out in advance)

On several occasions individual work groups met outside the monthly Advisory Committee meeting. F5SB staff and Harder+Company Staff also worked between monthly meetings to identify and obtain additional data requested by workgroups.

Data Sources

In most cases, data used by subcommittees to evaluate need was taken from publically accessible data sources. Some resources included: The 2010-11 San Bernardino County Indicators Report, Kids Count data, the U.S. Census, American Community Survey, and The California Childcare Portfolio. In some cases, committee members requested and were given access to data directly from the organizations that collected it. For example the Health subcommittee was given access to findings from the County Child Death Review Board in order to assess common causes of accidental death among young children in the county, and United Way provided a custom report showing the most frequent resource requests they received from parents of children age 0 to 5 years. Other sources of data included the First 5 San Bernardino Local Evaluation Report and California Health Interview Survey (CHIS).

Recommended Priorities by Focus Area

The following summary included the Advisory Committee's recommended priority areas, based on evidence of need in the county. Objectives from each focus area were taken from First 5 San Bernardino's Evaluation Framework and are aligned with state level objectives. Full evidence used to evaluate each area of need is provided in **Appendix 1**. **It is important to note that these are relative rankings and that lower priority objectives are still very important.** However, in the context of this process, Advisory members found some areas of need less urgent or they could not substantiate need based on the evidence currently available. (See regional data challenges.)

The Advisory Committee developed a rating system that was primarily based on evidence of county-level need. However, duplication of funding/services, evidence that objectives were measureable and that meaningful outcomes could be achieved with the funding available was also considered. A full description of the ratings and criteria associated with each rating is provided in **Table 2** below.

In some instances, it was evident that prioritizing one objective would address other related objectives. For example, in the Education Focus Area, *increase access to high quality child care programs* was given high priority. If that objective was strongly addressed, committee members felt it would additionally improve outcomes around two other objectives: *Increase the number of childcare providers recognized developmental needs and milestones of children and increase the percentage of children exhibiting healthy cognitive and social-emotional behaviors*. Those two objectives were subsequently given moderate priority with this understanding. We believe this represents an efficient way to leverage Commission resources.

Table 2. Guide to the Priority Ratings

The following guide describes the priority ratings used throughout this report.

Priority	Description
High priority Recommend primary funding for strategies addressing high priority objectives at a level sufficient to achieve outcomes	*High levels of need and low levels of duplication by other public agencies. There are county-level indicators that can be assessed for change and meaningful, achievable outcomes that can be measured.*
Moderate priority Recommend funding for strategies addressing these objectives once high priority objective areas are sufficiently funded to achieve outcomes	*Moderate levels of need and low levels of duplication by other public agencies. There are county level indicators that can be assessed for change and meaningful, achievable outcomes.*
Low priority Recommend funding only if high and moderate priority objectives are sufficiently funded to achieve outcomes	*Lower levels of need and/or some duplication by other agencies. There may be not be existing county-level indicators (or indicators may not be easily accessible) and /or measuring change over time may not be feasible. Outcomes are meaningful but not easily measureable in the short run.*
Not a priority Funding of strategies in this category not recommended at this time. This rating was not assigned to any strategy via this process.	*Objective designated not a priority because there is little to no evidence of need and/or substantial duplication by other agencies at this time. County-level indicators may or may not available or accessible, but the primary basis for this recommendation is based on need and duplication.*

Recommended Priorities: Health

Goal: Children and families are healthy and safe

The Health subcommittee recommends that resources address the following evidence-based needs:

High Priority:

- Reduce infant mortality, especially among the African- American population. Related to this priority, the subcommittee recommends programs that reduce prenatal drug/alcohol exposure and that prevent low/very low birth weight, seeing those two areas as root causes of infant mortality
- Reduce the occurrence of and improve the management of asthma and bronchitis in children ages 0 to 5

- Focus on reducing the rates of child abuse and neglect, domestic violence and unintentional injuries and death
- Increase the percentage of children 0 to 5 who have seen a dentist
- Decrease the percentage of children 0 to 5 experiencing dental caries (treated or untreated tooth decay)

Moderate Priority:

- Increase the percentage of women receiving prenatal care in their first trimester
- Increase access to healthy food
- Decrease the percentage of children age 2 to 5 who are overweight for their age

Low Priority[1]:

- Increase the number of infants receiving breast milk in the hospital
- Increase the number of infants who are exclusively breastfed

Recommended Priorities: Education

Goal: Children enter school ready to learn

The Education subcommittee recommends that resources address the following evidence-based needs:

High Priority:

- Increase the percentage of parents who are informed of and enroll their children in high quality subsidized child development programs
- Increase access to quality childcare programs
- Increase time parents spend reading, singing and telling stories to their children
- Increase the percentage of parents who use developmentally appropriate activities to support the school readiness of their children
- Increase family literacy skills
- Increase the percentage of children exhibiting age-appropriate development

Moderate Priority:

- Increase the number of childcare providers recognizing developmental needs and milestones of children
- Increase the percentage of children exhibiting healthy cognitive and social-emotional behavior

[1] San Bernardino County is a leader in Baby Friendly hospitals, an effort supported by First 5 San Bernardino for many years. The Advisory Committee felt this need would be addressed adequately by systems already in place.

Low Priority:

- Address the length of time childcare providers stay in the childcare field[2]
- Increase the number of children receiving developmental screening and intervention[3]

Recommended Priorities: Family Support

Goal: Families are safe, healthy, nurturing and self-sustaining

This subcommittee took a slightly different approach to establishing its priority recommendations. There are two objectives within the Family Support focus area: *Parents practice developmentally appropriate parenting;* and *Families are stable and have the capacity to meet the needs of their children.* For each of these objectives, the subcommittee identified target families and children that should be the focus of funding in these areas.

The Family subcommittee recommends that resources address the following evidence-based needs:

Objective: *Parents practice developmentally appropriate parenting (with the goal of reducing substantiated cases of child abuse and neglect):*

High Priority:

- Increase prevention and intervention services to families at risk, including teen parents and families experiencing conditions or circumstances that could result in abuse and neglect of children ages 0 to 5

Moderate Priority:

- Enhance services to families experiencing domestic abuse
- Enhance services to families experiencing substance abuse

Low Priority[4]:

- Target services to families experiencing homelessness
- Target services to prevent teen births

[2] CARES already provides funding and training designed to address this objective;

[3] Screenings were assigned a relatively lower priority because the committee could not find data to assess. However, the committee felt it important to note that efforts currently funded under Education and Systems are important in addressing this need objective.

[4] This area was given low priority because the subcommittee felt that other organizations/agencies already provide funding, services, and programs to address these needs.

Objective: Families are stable and have the capacity to meet the needs of their children:

High Priority:

- Target services for families in the most impoverished geographic regions, as indicated by poverty levels, high levels of WIC utilization, welfare and food stamps

Moderate Priority:

- Target services for families living in areas with high levels of access to drugs and alcohol

Low Priority:

- None Identified

Suggested Strategies

Although not expected by the Commission, the Advisory Committee members were able to suggest possible strategies for addressing the priority need areas which they have identified. These suggestions can be found in **Appendix 2**.

Regional Data Challenges

This process made it evident that ***there is a severe lack of regional and community level data relevant to the well-being of children 0 to 5 in San Bernardino County.*** When subcommittee members wanted to examine geographically specific data, it was frequently outdated or simply did not exist. This matters immensely to First 5 San Bernardino and to all organizations serving young children, in several important ways. First, the lack of data impedes the ability to document the needs of young children. Second, it makes it nearly impossible to measure the impact of the programs and services that have been funded in these communities. This can diminish our capacity as a County to attract and compete for funding from Federal, State, and private institutions.

Based on the learning and realization that occurred during this process, the Advisory Committee offers one final recommendation– that the Commission considers how ***First 5 could partner with and/or leverage the work of other agencies to improve the quality and availability of regional and community level data relevant to the well-being of children ages 0 to 5.*** Models of how this can work exist –for example, First 5 Los Angeles partners with WIC to include custom items on WIC surveys and to produce community-level reports of the findings. This activity, while not a direct service, could have a lasting impact on the well-being of children for decades to come.

Concluding Remarks

The needs of children 0 to 5 and their families are significant in San Bernardino County, especially with the reduction in services and resources brought about by the current economic downturn. The County ranks near the bottom of the 58 California counties on many important indicators of child well-being. The recommendations found in this report represent an effort to use the best evidence of need available to ensure that First 5 San Bernardino's resources are focused where they have the potential to do the most lasting good for children 0 to 5 with substantial and measurable outcomes.

The Advisory Committee acknowledges that need is not the only important criterion for determining where the Commission's dollars can do the most good. Other things matter too – specifically and in summary, the use of evidence based programs, the ability to measure change, and targeting resources in geographic areas or to other sub-groups where they are most needed. These issues will be addressed via the upcoming Request for Proposal (RFP) process.

Advisory Committee
Priority Recommendations Report
APPENDIX 1.
October 2011

TABLE OF CONTENTS

Advisory Committee
Priority Recommendations Report
APPENDIX 1.
October 2011

Subject **Page**

HEALTH Section (continued)

Advisory Committee
Priority Recommendations Report
APPENDIX 1.
October 2011

Subject **Page**

Advisory Committee
Priority Recommendations Report
APPENDIX 1.
October 2011

EDUCATION Section (continued)

Subject **Page**

Advisory Committee
Priority Recommendations Report
APPENDIX 1.
October 2011

Subject **Page**

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

HEALTH	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
3-High	**Children are born healthy**	*Low and very low birth weight* Low birth weight: percent of newborns weighing less than 2,500 grams Very low birth weight: percent of newborns weighing less than 1,500 grams	**LOW BIRTHWEIGHT (2007-2009 three year average)** San Bernardino County: 7.1% California: 6.8% Rank: 8th worst among 58 California counties National Objective (HP 2010): 5.0% **VERY LOW BIRTHWEIGHT (2007-(2009)** San Bernardino County: 1.4% California: 1.2% National Objective (HP 2010): 0.9%	Low birth weight babies face 6 to 10 times the risk of infant mortality, and are at increased risk of long-term disabilities, including mental retardation, chronic respiratory problems, cerebral palsy, childhood psychiatric disorders, autism, and hearing and vision impairments. Women who are more likely to give birth to low birth weight babies include those with low incomes, inadequate prenatal care, smoking habits, and those under age 16 or over 45 years old. Despite being a small portion of all live births, low weight infants account for more than one-third of all dollars spent on infant health care.

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

HEALTH	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
3-High	**Children are born healthy**	Services available to women: newborns born alcohol/drug exposed per 1,000 live births	**NEWBORNS BORN ALCOHOL/DRUG EXPOSED (2009)** San Bernardino County: 4.7 Riverside County: 3.2 California: 4.1	*- Women who use alcohol or illicit drugs while pregnant are at a higher risk for delivering babies with birth defects, growth retardation, and diminished cognitive development *- Increasing awareness of available social services helps to increase awareness of prenatal and perinatal substance use resources
3-High	**Children are born healthy**	Infant mortality rate: infant deaths per 1,000 cohort live births	**ALL RACE/ETHNIC GROUPS INFANT MORTALITY RATE (2006-2008 three year average)** **BLACK INFANT MORTALITY RATE** San Bernardino County: 13.7 per 1,000 cohort live births **(Continued on next page)**	*- Access to health care is a concern *- Not many clinics that offer access to health care for free or sliding scale *- Focus on prenatal to one year of life and target interventions for infants *- The primary causes of infant mortality are birth defects, disorders related to short gestation/low birth weight, Sudden Infant Death Syndrome (SIDS), and issues related to pregnancy and birth, including substance abuse

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

HEALTH	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
(Continued from previous page)	**(Continued from previous page)**	Infant mortality rate: infant deaths per 1,000 cohort live births	**ALL RACE/ETHNIC GROUPS INFANT MORTALITY RATES** Rank: 11th worst among 58 California counties California: 12.3 per 1,000 cohort live births National Objective (HP 2010): 4.5 per 1,000 cohort live births **WHITE INFANT** San Bernardino County: 6.1 per 1,000 cohort live births Rank: 14th worst among 58 California counties California: 4.6 per 1,000 cohort live births National Objective (HP 2010): 4.5 per 1,000 cohort live births **HISPANIC INFANT** San Bernardino County: 5.6 per 1,000 cohort live births Rank: 18th worst among 58 California counties California: 5.2 per 1,000 cohort live births National Objective (HP 2010): 4.5 per 1,000 cohort live births	*- Proper prenatal and well-baby preventive care offer opportunities to identify and ameliorate some risk factors for infant mortality

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

HEALTH	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
3-High	**Children are raised in safe and nurturing environments**	*Child abuse/neglect* Unsubstantiated cases of child abuse/neglect: unsubstantiated reports of child abuse and neglect per 1,000 children ages 0-17 years Substantiated cases of child abuse/neglect: substantiated reports of child abuse and neglect per 1,000 children ages 0-17 years	**UNSUBSTANTIATED CASES OF CHILD ABUSE/NEGLECT *(2009)*** San Bernardino County: 58.8 California: 50.0 **SUBSTANTIATED CASES OF CHILD ABUSE/NEGLECT *(2009)*** San Bernardino County: 7.6 California: 10.0	*- Children who are abused or neglected, including those who witness domestic violence, often exhibit emotional, cognitive, and behavioral problems, such as depression, suicidal behavior, difficulty in school, use of alcohol and other drugs, and early sexual activity *- Children who are abused or neglected are more likely to repeat the cycle of violence by entering into violent relationships as teens and adults or abusing their own children
3-High	**Children are raised in safe and nurturing environments**	Domestic violence: domestic violence calls for assistance per 1,000 population	**RATE OF DOMESTIC VIOLENCE CALLS FOR ASSISTANCE *(2008)*** San Bernardino County: 5.6 California: 6.6	*- In 30% to 60% of families that experience domestic violence, children also are abused. *- Children who witness domestic violence exhibit the same emotional, behavioral, and academic problems as abused children. *- Children raised in violent family environments are at risk of becoming abusers or victims during adolescence or adulthood.

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

HEALTH	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
3-High	**Children are raised in safe and nurturing environments**	Unintentional injuries: rate of death of children ages 0-5 years, due to all unintentional injury causes, per 100,000 population ages 0-5 years	**UNINTENTIONAL INJURY DEATH RATE (2009)** San Bernardino County: 11.3 Riverside County: 8.6 California: 6.8	*- Unintentional injuries are more common than intentional injuries and are often preventable *- Many unintentional injuries result from child abuse/neglect, motor vehicle accidents, drowning, firearm accidents, bicycle and skateboarding accidents, and falls
3-High	**Children are healthy, well nourished and physically fit**	Asthma/bronchitis: rate of hospitalization of children ages 0-5 years, due to asthma or bronchitis, per 100,000 children ages 0-5 years	**ASTHMA/BRONCHITIS HOSPITALIZATION RATES (2009)** San Bernardino County: 831.0 Riverside County: 519.9 Los Angeles County: 628.4 California: 578.0	*- Hospitalizations reflect the most severe illnesses, injuries, and symptoms among children *- Asthma impacts levels of physical activity, particularly among children *- Environmental toxins, air pollution, and secondhand smoke are considered contributing factors to asthma *- Children without access to regular medical care are more likely to suffer from serious episodes that may result in trips to the emergency room and even hospitalization

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

HEALTH	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
3-High	**Children are healthy, well nourished and physically fit**	*Oral Health* Percent of children 0-5 who have never seen a dentist Percent of children 0-5 who do not currently have dental insurance Percent of children in kindergarten who have had a caries experience (treated or untreated tooth decay)Untreated tooth decay: percent of children in kindergarten who have untreated tooth decay	**Percent of Children 0 to 5 who have never seen a dentist *(*2009)** San Bernardino County: 23.6 California: 27.3 **NO CURRENT DENTAL INSURANCE *(*2007)** San Bernardino County: 19.8 California: 17.6 **CARIES EXPERIENCE *(*2005)** San Bernardino County: no data available California: 53.6 **UNTREATED TOOTH DECAY *(*2005)** San Bernardino County: no data available California: 27.9	Tooth decay is the most common preventable illness affecting US children today In California tooth decay among young children has increased over the past two decades. When left untreated tooth decay can contribute to a wide range of problems including infection, poor nutrition, subnormal growth, and unnecessary pain Oral Health disease is estimated to cause children to miss over 51 million hours of school annually American Academy of Pediatric dentistry advises that children visit the dentist within 6 months of getting their first tooth and no later than their first birthday

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

HEALTH	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
2-Moderate	**Children are healthy, well-nourished, and physically fit**	*Access to healthy food* *Retail food environment index: ratio of unhealthy food retail sites to healthy food retail sites *Food hardship rate: percent of families with children reporting that there were times over the past year when they did not have enough money to buy needed food	**RETAIL FOOD ENVIRONMENT INDEX (2005)** San Bernardino County: 5.72 California: 4.2 Rank: Worst among 58 California counties **FOOD HARDSHIP RATE (2011)** San Bernardino & Riverside Counties: 30% California: 27% Rank: 8th worst metropolitan area in the United States	The likelihood of being obese is influenced by the food environment Prolonged food hardship can lead to infant deaths, low birth weight infants, anemia, retarded physical growth and impaired brain development
2-Moderate	**Children are healthy, well-nourished, and physically fit**	Overweight/obesity: percent of children ages 2-5 years who were overweight for their age	**OVERWEIGHT/OBESITY RATE (2007)** San Bernardino County: 10.2% California: 10.2%	*-Young children that are overweight or obese are more likely to be overweight or obese throughout life *-Health risks for children who are overweight or obese include heart disease, diabetes, asthma, sleep apnea, and social discrimination *-Overweight or obese children may not fit safely in car seat, leading to higher risk of unintentional injury

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

HEALTH	**DATA AND INDICATORS WORKSHEET**			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
2-Moderate	**Children are born healthy**	*Prenatal care and teen birth rate* Prenatal care: percent of mothers giving birth who did not begin prenatal care during first trimester of pregnancy Teen birth rate: live births to mothers ages 15-19 years per 1,000 females ages 15-19 years	**PRENATAL CARE NOT BEGUN DURING 1ST TRIMESTER OF PREGNANCY (2007-2009 three year average)** San Bernardino County: 18.6% Rank: 41st worst among 58 California counties California: 17.3% National Objective (HP 2010): 10.0% San Bernardino County, by mother's race/ethnicity: African American: 24.2% White: 17.0% Latino: 19.5% **BIRTH RATE FOR TEEN MOTHERS AGES 15-19 YEARS** San Bernardino County: 44.4 Rank: 11th worst among 58 California counties California: 34.7 National Objective (HP 2010): None	*-Inadequate prenatal care is linked to nutritional deficiencies in the mother and baby *-Inadequate prenatal care is also linked to adverse outcomes such as premature births, lower birth weight, and higher infant mortality *-Low-income women, teenagers, immigrants, those with language barriers, and those who are socially isolated are at most risk for poor birth outcomes; however, these groups are less likely to get prenatal care *-Through prenatal care, health professionals are able to identify and resolve potential medical problems and provide guidance and encouragement on good habits for a healthy pregnancy

APPENDIX 1.

Evidence of Need Worksheets

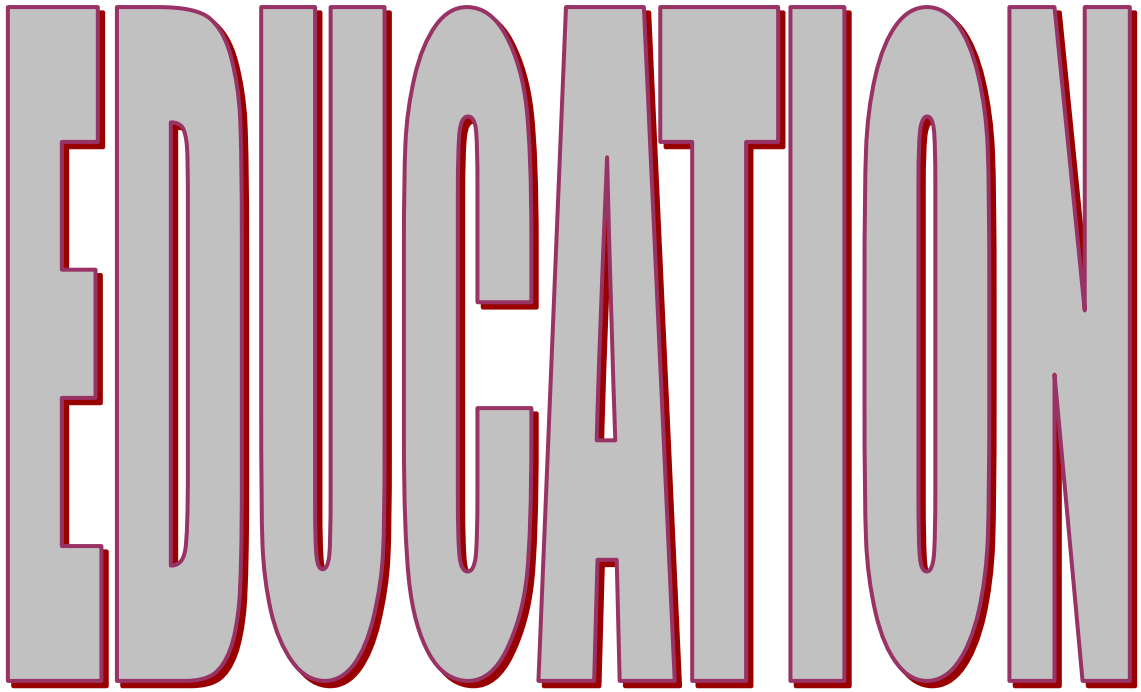
Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

HEALTH	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
1-Low	**Children are healthy, well nourished and physically fit**	*Breastfeeding* • Any breastfeeding: percent of newborns fed breast milk in the hospital • Exclusive breastfeeding: percent of newborns fed breast milk ONLY in the hospital	**ANY BREASTFEEDING (2009)** San Bernardino County: 84.3% Rank: 11th worst among 58 California counties California: 89.6% **EXCLUSIVE BREASTFEEDING (2009)** San Bernardino County: 50.8% California: 52.0%	• Infants who are breastfed receive protection from serious health conditions, including respiratory infections, allergies, asthma, and obesity. • Studies indicate that breastfeeding can reduce the incidence of Sudden Infant Death Syndrome (SIDS), when compared to formula feeding.

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.



APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

EDUCATION	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
3-High	**Children have access to high quality early childhood developmental program**	6.3. increased number/percent of parents informed of, and number/percent of children enrolled in high quality subsidized child development program	*- Number of children seeking to receive help paying for childcare is 13,205. *- 11% of children are in preschool, nursery school, and Head Start 10 hours or more per week in SB; 16.% in the state (CHIS Report)	This numbers can increase if CDE cuts funding for child development. The need may increase because SR programs are ending in June and children need to be added here.
3-High	**Children have access to high quality early childhood developmental program**	6.5. Improved access to quality childcare programs	*- There are license spaces for only 21% of children 0-13 years who's parents are working – ranked 56th out 58 counties (Childcare R and R Portfolio) *- 67% of schools do not have API (Academic Performance Indicator) scores at the state target (SBC Community Indicator Report) *- 82% of our schools are below AYP (Adequate Yearly Performance) in 2009 (SBC Community Indicator	Subsidized waiting list numbers have been higher because parents can't afford private programs.
3-High	**Children live in a home environment supportive of learning**	4.1 Increased parents' time spent reading, singing, and tell stories to their children	*- For SB, 56.2% read every day to child; 15.2% never read to child (CHIS) *- For State, 65% read every day: 4.8% never read to child (CHIS)	*- F5 parents may be representative of other parents in the county. *- SR program capture variety of demographics. Some programs were serving parents who did not quality for state preschool or Head Start; infant/toddler program probably served low income parents

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

EDUCATION	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
3-High	**Children live in a home environment supportive of learning**	4.2. Increased number/percent of parents using developmentally appropriate activities to support SR of their children	*- Parents knowledge of child's developmental needs is at mid-point (3 out of 6; F5SB Eval Report *- Parents engagement with learning related activities (less than 60%) are lower than care taking activities (above 70%; F5SB Eval Report- Table 3.19)	*-F5 parents may be representative of other parents in the county. SR program capture variety of demographics. Some programs were serving parents who did not quality for state preschool or Head Start; infant/toddler program probably served low income parents
3-High	**Children develop within normal ranges in all domains**	7.1 increased number/percent of children exhibiting age-appropriate development	ASQ3 results (% of children below cut off): Communication 34.7%/gross motor 20.7%/fine motor 25.6%/problem solving 28.1%/personal social 25% (F5 Eval Report - SART)	DRDP data seem to suggest infant/toddler are not as negatively affected by the lack of positive social interaction in learning experiences
3-High/ 2-Moderate	**Children live in a home environment supportive of learning**	4.3 Increased family literacy skills	43.7% of SR parents had not graduated from HS (F5SB Eval Report)	
2-Moderate	**Children have access to high quality early childhood developmental program**	6.1 Increased number of childcare providers recognizing developmental needs and milestone of children	59% of agencies have an active parent component to increase knowledge and skills for preparing children to enter school (Childcare Planning Council Survey) 81% of agencies offer staff professional growth opportunities (Childcare Planning Council Survey) 91% of agencies are aware of professional growth opportunities relating to developmental needs (Childcare Planning Council Survey)	

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

EDUCATION	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
2-Moderate	**Children develop within normal ranges in all domains**	7.2. increased number/percent of children exhibiting healthy cognitive and social emotional behavior	*- CHIS results for risk of developmental delay: 15.4% high risk in SB; 20.1% in state 15.9% moderate risk in SB; 19.7% in state 31.4% low risk in SB; 18.8% in state (DRDP preschool results from SR - F5 Eval Report) *- At "pre" most children are in the "exploring" and "developing" stage (scores range from 1.8 to 2.12) *- Effective learning (1.65) and personal and social competence (1.80) is lowest *- On 4 point system DRDP infant/toddler results are a little higher (on a 5 point system)	DRDP data seem to suggest infant/toddler are not as negatively affected by the lack of positive social interaction in learning experiences
1-Low Note: There are other good programs like CARES and AB212	**Children have access to high quality early childhood developmental program**	6.2 Length of time childcare providers stay in the childcare field	*- 32% with 10+years of experience *- 24% with 6-10 years *- 17% with 3-5 years *- 12% with 1-2 years 15% with less than 1 year of experience (Childcare Planning Council Survey)	*- KidsnCare data numbers may be higher than in the F5SB Eval report because providers who responded are working in the field and are connected to child development activities. *- CARES/CONNECTIONS programs may include those who are not currently working as providers. *- State has the CARES Plus which will start in July ($1.2 million)

APPENDIX 1.

Evidence of Need Worksheets

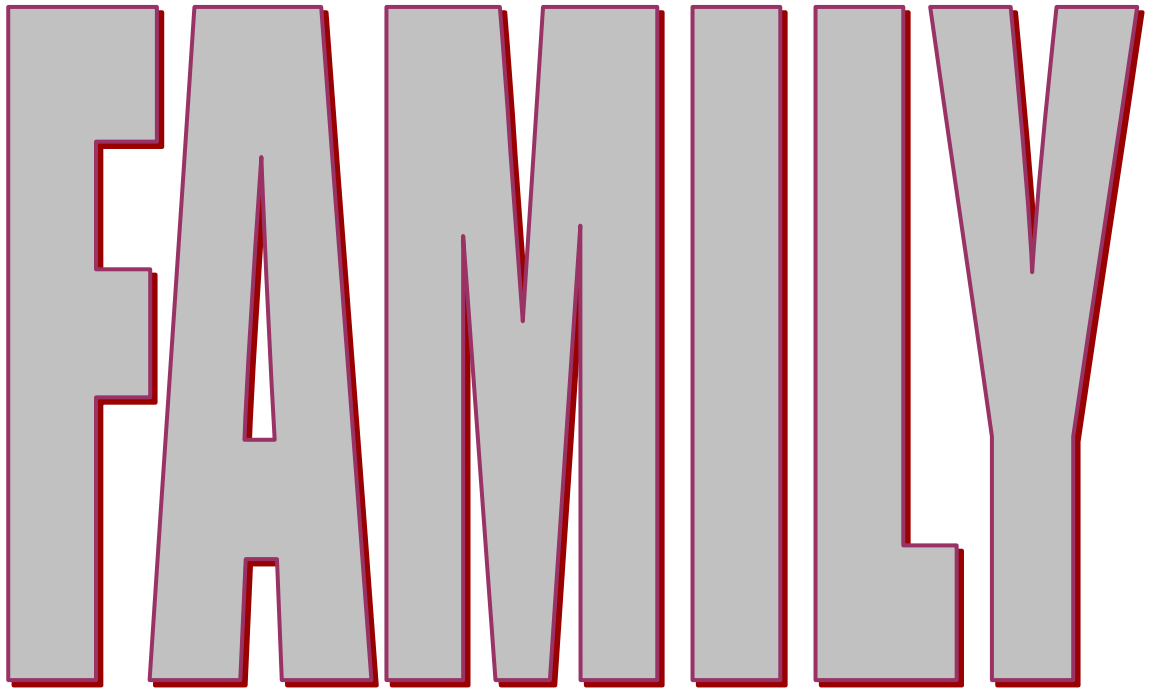
Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

EDUCATION	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
1-Low Note: Don't have enough data and there are programs like SART	**Children receive early screening and intervention for special needs**	5.1 Improved screening, assessment, referral and	Children receive screening through SART. There are screening in schools/preschools but not sure to what extent for non-First 5 services). Inland Regional does screenings. 77% of children screened but 7% were diagnosed. Of those diagnosed, 39% had speech delays (F5 Family Survey)	Don't have enough data and there are programs like SART

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.



APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

FAMILY	DATA AND INDICATORS WORKSHEET			
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
3-High	**Parents practice developmentally appropriate parenting skills (focus on high risk target populations)**	* - Child abuse *_ % Reoccurrence of Child abuse for families with 0-5 *- Rate of substantiated child abuse allegations	*- 12.5% of substantiated child abuse reoccurring after 12 months *- Increasing trend since 2005 *Children's Network*	*- Future success of children: exposure to trauma and neglect puts children high risk of substance abuse, mental health *- Children 0-5 are at highest risk of death from child abuse
3-High	**Families are stable and have the capacity to meet the needs of their children (focus on high need geographic areas)**	Utilization of WIC, Food stamps, welfare, poverty	*- 19.1% of families on WIC in San Bernardino *- 23.6% of families with 0-5 using food stamps *- Welfare data by city (AFDC/TANF)	
2-Moderate	**Parents practice developmentally appropriate parenting skills (focus on high risk target populations)**	Domestic violence cases	*- Number of Police department calls for DV *- Number of DV cases	*- Domestic violence is an emotional trauma *- Increased exposure to violence leads to long-term psychological effects
2-Moderate	**Parents practice developmentally appropriate parenting skills (focus on high risk target populations)**	Substance abuse cases	Number of people convicted of substance abuse crimes that are parents	*- Substance abuse leads to increases in homelessness and instability; increased anxiety and depression for children *- Substance abusing parents may be providing inadequate supervision to their children
2-Moderate	**Families are stable and have the capacity to meet the needs of their children (focus on high need geographic areas)**	Access to drugs	*- Alcohol outlet density by city *- Medical marijuana outlet density (?) *- Drug crime data by city	

APPENDIX 1.

Evidence of Need Worksheets

Each Advisory Committee Subcommittee documented the evidence used in their prioritization process in the documents found in this appendix.

FAMILY		DATA AND INDICATORS WORKSHEET		
Priority **3=high 2=moderate** **1=low** **0=not a priority**	**Objective**	**Indicator** **(How we are measuring need)**	**Evidence of need**	**Importance/Significance**
1-Low	**Parents practice developmentally appropriate parenting skills (focus on high risk target populations)**	Homeless families	Prevalence of homelessness Number of families homeless (ever) Average amount of time families report homelessness	*- Lowest priority due to the need being so great F5SB may not be able to do it all or accomplish measurable results *- There are other efforts toward this issue
1-Low	**Parents practice developmentally appropriate parenting skills (focus on high risk target populations)**	Teen birth rate	51/1000 teen birth rate for San Bernardino County	*- Important to catch young parents early to correct any problem parenting behaviors *- Low priority due to other efforts
1-Low	**Combination of all three needs with an emphasis on:**	Families are stable and have the capacity to meet the needs of their children (focus on high need geographic areas)	Crime rates	Violent crime rates by city

Advisory Committee
Suggested Strategies by Priority Focus Area
APPENDIX 2.
October 2011

TABLE OF CONTENTS

Advisory Committee
Suggested Strategies by Priority Focus Area
APPENDIX 2.
October 2011

Subject **Page**

Advisory Committee
Suggested Strategies by Priority Focus Area
APPENDIX 2.
October 2011

Subject **Page**

APPENDIX 2.

Suggested Strategies by Priority and Focus Area

HEALTH

Objective	Priority	Indicator	Suggested Strategies
Children are Born Healthy	High	Reduce low/very low birth weight Reduce alcohol/drug exposure Reduce infant mortality rate	• Increased utilization of 211 (3) • Promote 100% utilization of WIC (3) • Social networking wellness campaign in addition to GPS/location based services (2) • Need is high for African American population in regards to entering prenatal care early (1) • Awareness campaigns
Children are Born Healthy	Moderate	Increase number of women receiving prenatal care in the first trimester	• Increased collaboration with OB/GYN providers-especially for low income populations (5) • Increased knowledge of available services by telling churches; outreach through faith communities
Children are Born Healthy	Moderate	Reduce teen birth rate	• Collaboration with schools; bring awareness of child development pre-natal through first 5 to educate all of our youth (high school)- through the school systems (8) • Reducing the stigma in regards to birth control (3) • Prenatal services (2) • Teen education (2) • Safe surrender program type model for admitting pregnancy and receiving services
Children are healthy, well nourished and physically fit	High	Reduced rate of hospitalization due to asthma/bronchitis	• Supplemental insurance support to cover asthma supplies, i.e. inhalers (7) • Early and ongoing screening for asthma detection; in home screening (5) • Survey about parents ability to access health care and manage child's asthma (2) • Parent education (2)
Children are healthy, well nourished and physically fit	Moderate	Increase access to healthy food	• Having consistent messages about healthy eating: home, school, work, churches (6) • Cooking and nutrition classes (3) • Encourage neighborhood gardens (1) • Improve health food availability • Prevention care education
Children are healthy, well nourished and physically fit	Moderate	Reduce the number of children 2-5 who are overweight for their age	
Children are healthy, well nourished and physically fit	Low	Increase number of infants receiving breast milk in the hospital	
Children are healthy, well nourished and physically fit	Low	Increase number of infants exclusively breastfed	

APPENDIX 2.

Suggested Strategies by Priority and Focus Area

HEALTH

Objective	Priority	Indicator	Suggested Strategies
Children are raised in safe and nurturing environments	High	Reduce child abuse and neglect Reduce incidents of domestic violence Reduce the rates of unintentional injuries and death	• Parenting classes; educate parents in childcare education; ongoing parent education in regards to injury risk by child's age and developmental stage; systems: integrate in jury prevention efforts and adopt consistent messages and curricula (7) • Family resource center; direct families to resources (7) • Prevent alcohol and drug abuse services and child abuse; in regards to domestic violence, substance/alcohol abuse prevention and recovery services (6) • Assist victims of domestic violence; shelters, counseling (4) • Increase supportive services to reduce abuse indicators (causes); provide/support child abuse prevention services (3) • Increased collaboration with CBO's (i.e. churches, organized groups) and inter-city collaboration (2) • Legislation to change city general plans relative to number of liquor stores in neighborhoods (1) • Staff training on recognizing signs of abuse/neglect combined with knowledge of referral sources (battered women's shelters (1) • Photo voice (1) • Family Support group • Increased awareness through education and sharing of data • Utilize information technology to contribute to systems integration; interagency collaboration • Youth education about teen dating violence

APPENDIX 2.
Suggested Strategies by Priority and Focus Area

EDUCATION

Objective	Priority	Indicator	Suggested Strategies
Children have access to high quality early childhood developmental programs	High	% of parents informed of and children enrolled in high quality subsidized child development programs	• School readiness system integrated into something like resource and referrals (3) • Having quality rating scales for program so that people will be informed (5) • Increase capacity by training and supporting potential providers to become licensed • Provide teaching model for parents (i.e., home school type model, a cookbook, or "what do when you're expecting" book) (4) • Marketing through flyers, ratio, billboards, supermarkets, post offices. Where parents frequently go (1) • To improve access look at cost and transportation barriers (5) • Awareness through churches and day care centers • Increase availability of information on when and how to find these resources (8)
Children have access to high quality early childhood developmental programs	High	Improved access to quality childcare programs	
Children have access to high quality early childhood developmental programs	Moderate	Increased number of childcare providers recognizing developmental needs and milestones of children	
Children have access to high quality early childhood developmental programs	Low	Length of time childcare providers stay in the childcare field	
Children live in a home environment supportive of learning	High	Parent time spent reading, singing and telling stories to their children Parents using developmentally appropriate activities to support the school readiness of their children	• Develop strong parent teacher bond. Even prior to first day of school. When school begins begin to "partner" in regards to implementation of curriculum • Teacher home-visitation. Teacher should be able to visit homes of children and perhaps help parents create an environment of learning in the home (lighting, design, away from distraction, etc.) (5) • Detailed information for parents about the school system and expectations of elementary school
Children live in a home environment supportive of learning	High/moderate	Family literacy skills	• Detailed information for parents about the school system and expectations of elementary school • Increase literacy skills and ESL classes for parents (Partnerships with libraries) (3) • Give class credit and other incentives to parents for reading to their school (1) • Family literacy and language program and providing training prompts for parents to help children with oral language • Marketing campaign to highlight – "teachable moments" (4) • Ensure parents have computer or internet access (1) (continued on next page)

APPENDIX 2.
Suggested Strategies by Priority and Focus Area

EDUCATION

Objective	Priority	Indicator	Suggested Strategies
Children live in a home environment supportive of learning	High/moderate (continued)	Family literacy skills (continued)	• Parents awareness of the importance of their support to the children at home as well as school • Improve access to existing free and low cost activities for families (e.g., libraries, museums, parks, playgrounds, trails, etc.) via promotion, free passes, community networks/integration (4) • Oral language development (1) • Video recording of parent-child discussions and activities • Family night-reading stories and having conversations (8) • Connect parents success in family literacy with other FRC services • Have family reading nights • Create family friendly setting while parents participate in school related activities (e.g. during PTA meetings provide food and homework assistance, younger child care. • Faith-based setting for fun learning of singing, story telling, taking advantage of teachable moments
Children receive early screening and intervention for special needs	Low (lack of data and presence of programs like SART)	Improved screening, assessment and referral	• Do periodic testing to assess kids before the annual required testing to catch problem early (7) • Continue programs like SART (3) • If other resource not available this should be higher priority • Universal preschool (4) • Increase the accuracy of the screening to determine the real needs of kids to implement the right intervention Support special health care need services for children (1) • Community stakeholders should be able to participate in community health fairs supported by local health agencies, doctors, nurses, local school and community centers. (2) • Universal screening approach like LA County developmental screening on 211 (2) • Early referral for services for special health care children (2) • Make parents aware of the developmental stage of different ages (6) • Mobile coaching or support for preschool teachers to deal with children with problems (5) • More training for teachers to identify special needs clearly (2) • Awareness campaign for educators to attend training
Children develop within normal ranges in all domains	High	Percent of children exhibiting age-appropriate development	
Children develop within normal ranges in all domains	Moderate	Percent of children exhibiting healthy cognitive and social-emotional behavior	

APPENDIX 2.
Suggested Strategies by Priority and Focus Area

FAMILY SUPPORT

Objective	Priority	Indicator	Suggested Strategies
Parents practice developmentally appropriate parenting skills (focus on high risk target populations)	High	* - Child abuse: reoccurrence of child abuse for families with children 0-5 *- Rate of substantiated child abuse allegations	• Help provide linkage to parent services (6) • Shaken infant, co-sleeping, safe surrender, baby safe campaign- hospital, doctor's office TAD, WD (6) • Using innovative ways to provide education to parents about child's developmental stages e.g. Facebook, Twitter (4) • Home visitation, coaching (4) • Wraparound 0-5 (3) • Free Parenting classes that are offered at convenient times with daycare available (2) • Partnerships: Partner with TAD to provide parenting information, special programs in DV shelters, collaboration with CBO's (1) • Substance abuse support: universal messages on risk factors for substance abuse, in-patient substance abuse programs for parents with 0-5, ensure parents access to substance abuse prevention and recovery programs (1) • Parent education (1) • Remove barriers to parent services • Front end alternative response support-case management to high risk families and post reunification support services (1) • Increased before and after school care services in neighborhoods • Create cultural norms for appropriate parenting practices • Incorporate what "appropriate parenting skills" actually means into health education curricula in high school
	Moderate	*- Domestic violence *- Substance abuse	
	Low	*- Homeless families *- Teen birth rate	
Families are stable and have the capacity to meet the needs of their children (focus on high need geographic areas)	High	Utilization of WIC, food stamps, welfare, poverty	• Family Resource Centers and Wraparound Services (8) • Housing Assistance, Utilities, food and basic needs (6) • Training Campaigns within TAD aimed at parents (6) • Celebrate success and advertise them (2) • Increased awareness of data and need(1) • Improve reporting to determine intervention • Use unemployment office as point of contact • Link Parents to job training and placement resources
Families are stable and have the capacity to meet the needs of their children (focus on high need geographic areas)	Moderate	Access to drugs & alcohol	